

8-6-1997

DDASaccident077

Humanitarian Demining Accident and Incident Database
AID

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DDAS Accident Report

Accident details

Report date: 19/04/2006	Accident number: 77
Accident time: 12:00	Accident Date: 06/08/1997
Where it occurred: Gulany Haji Farag, Derbandikhan District	Country: Iraq
Primary cause: Management/control inadequacy (?)	Secondary cause: Management/control inadequacy (?)
Class: Demolition accident	Date of main report: 25/08/1997
ID original source: SB/AS	Name of source: MAG
Organisation: [Name removed]	
Mine/device: PMN AP blast	Ground condition: not recorded
Date record created: 23/01/2004	Date last modified: 23/01/2004
No of victims: 1	No of documents: 1

Map details

Longitude:	Latitude:
Alt. coord. system:	Coordinates fixed by:
Map east:	Map north:
Map scale: not recorded	Map series:
Map edition:	Map sheet:
Map name:	

Accident Notes

inconsistent statements (?)

protective equipment not worn (?)

inadequate medical provision (?)

inadequate training (?)

victim squatting and stepped on mine (?)

no independent investigation available (?)

inadequate investigation (?)

Accident report

The demining group was operating a three-man team with a two-man drill at the time of the accident. One man used the detector, marked any readings, and another man came forward to excavate the reading, feel for tripwires and cut any undergrowth. A third man at any one time was resting.

A "Senior Mines Specialist" for the demining group carried out an investigation and the report was made available. There was considerable doubt about the reliability of the statements taken during an original investigation so further interviews were conducted and the report prepared (not dated but sometime after 24th August) from which the following is taken. There were two separate accidents occurring five minutes apart at the same site. This was the first of these accidents.

A deminer [the victim in a later accident on the same day] began clearance and located a PMN. He informed the Team Leader and then continued work and located another two PMNs. He then moved to the end of the clearance lane and found a further three PMNs. As he worked he marked the lane by taking markers from the right side and putting them on the left side. Each of the discovered mines was marked with a wooden picket.

The supervisor arrived when the Team Leader had prepared four of the PMNs for demolition. He was crouching over the fifth when it exploded. The supervisor stated that the victim was ripping a piece of tape at the time.

The supervisor organized the recovery of the victim who had been thrown into a cleared area. He was given first aid and taken to the Emergency hospital in Sulymania. He was not given an IV cannula.

[The protective equipment used by the victim was not recorded.]

The investigator observed that an internal memo dated 27th February had been circulated. The memo advised that the utmost care be taken when probing and excavating in a PMN minefield and that after a PMN was found the deminer should spend the minimum amount of time near it. It further advised that the mine should be destroyed as soon as possible, with the charge being placed from a prone position. The investigator noted that if the memo had been acted upon, the accident would have been avoided.

Recommendations

The investigator recommended that all staff should be briefed on the need to adhere to SOPs, that staff should be told that if they saw unsafe practices they could refuse to work, that an addition to SOPs should be written to cover PMN minefields, and that medics must be told "again" to administer an IV cannula to all mine casualties.

Victim Report

Victim number: 107	Name: [Name removed]
Age:	Gender: Male
Status: supervisory	Fit for work: no
Compensation: not made available	Time to hospital: 1 hour 30 minutes
Protection issued: Frag jacket	Protection used: not recorded
Helmet	
Short visor	

Summary of injuries:

INJURIES

minor Arm

severe Body

severe Eye

severe Genitals

severe Legs

AMPUTATION/LOSS

Leg Below knee

Genital

COMMENT

See medical report.

Medical report

A formal medical report from the Emergency hospital (dated 03/09/97 was made available. The following reproduces its content.

Admitted 06/06/97 following a mine injury.

Operation

- 1) Right eye: Upper partial thickness 94mm) corneal wound, multiple corneal FBs removed. AC reformed, upper eyelid injury repaired. (Ophthalmic surgeon)
- 2) Left below knee amputation.
- 3) Laparotomy and diverting colostomy for damaged anal canal and rectum.
- 4) Bilateral orchidectomy.
- 5) Debridement of perineum.

Patient in very bad general condition. 5 units of blood given.

07/08/97 Right eye. Hazy cornea. AC formed.

08/08/97 Review operation. Extensive DBR done. Anal sphincter still preserved. Rectal wound sutured.

11/08/97: Delayed primary suture to amputation stump.

DBR perineum, Left thigh, Right forearm.

18:30 Abdominal distention, coffee ground aspirate through naso-gastric tube.

12/08/97 Dressing under GA for all wounds.

13/08/97 2 units blood.

16/08/97 2 units blood given.

21/08/97 DBR: some wounds fairly clean DPC right and left legs and right hand.

23/08/97 Both eyes OK. Visual acuity good (Ophthalmic surgeon)

29/08/97 DPC further wounds

Spiking fever. Trial of chloroquin therapy.

30/08/97 Urethral catheter removed.

31/08/97 Left stump bone exposed. Later re-amputation required.

01/09/97 General condition: improving

Mobilisation commenced.

Should regain bladder control after 5-7 days bladder training.

Some serious discharge from large perineal wound which is healing slowly.

Amputation stump will require revision.

Colostomy can probably be closed after perineal wound has healed (about 3 months).

Analysis

The primary cause of this accident is listed as a "*Management/control inadequacy*" because the victim was a supervisor who was in breach of SOPs as he set the charges. Responsibility for the selection, training and control of field supervisors lies with senior management.

No mention was made of whether the victim was wearing his safety equipment. The lower abdomen injury may imply that he was not wearing his frag-jacket or could simply reflect the fact that the jacket was short.

The practice of exposing mines and working on beyond them in the same lane is not widespread and is considered dangerous by some.